1 June 2018

Karl Bloxham
fyi-request-7798-25d55219@requests.fyi.org.nz

Dear Mr Bloxham

Ref: 0051955

Official Information Act Request

Thank you for your request of 11 May 2018, asking for the following information under the Official Information Act 1982 (the Act).

- *Case Managers guidelines for handling mental injury claims.*
- *Guidelines when a claimant's mental injury impairs their ability to understand or consent to an IRP [independent rehabilitation plan].*
- *Guidelines relating to when the claimants should need assistance when considering an IRP due to their mental injury.*
- *Guidelines for getting the claimant to agree an IRP when they have a mental injury.*
- *Guidelines relating to an IRP and what can be subject to a reviewed decision.*

Background

Before answering your request for information, we would first like to provide you some background information about the role of case managers at ACC. Case managers provide a needs-based service in order to achieve the best possible outcome and durable independence for their clients. Case managers work in a partnership relationship with the client through all the stages of their treatment and rehabilitation process. This is achieved through cooperative, informed and participative decision-making and goal setting through the development of an individual rehabilitation plan. The case manager will act on the recommendations made by the client's treatment providers and assessors.

Our response

ACC has a single source of policy, process and guidance information on its intranet site. This is to assist ACC staff who work with clients. We are providing you with a selection of pages from the intranet, regarding guidelines about mental injury claims and independent rehabilitation plans, relevant to your request. Please find these 13 documents attached, as listed at the end of this letter.

We also note the following pages that relate to your current request were provided to you on 22 November 2017 (Ref: 0050901), and are therefore not reproduced in this response.

- Guidelines for creating Individual Rehabilitation Plans
- Individual Rehabilitation Plans policy
- Creating or updating an Individual Rehabilitation Plan process
- Creating or updating a paperless IRP process
- Individual Rehabilitation Plans FAQs
- Social rehabilitation and individual rehabilitation plans policy
- Client Centric Individual Rehabilitation Planning template

Withheld information
We have withheld staff names from the documents under section 9(2)(a) of the Act, as there is a need to protect the privacy of natural persons. ACC has carefully considered whether there are reasons why it is desirable, in the public interest, to make the information available. ACC is of the view that maintaining an individual's privacy outweighs any public interest in making the information available.

Queries
If you have any questions about the information provided, you can contact us at GES@acc.co.nz.

You have the right to complain to the Office of the Ombudsman if you are unhappy with our response. You can call them on 0800 802 602 between 9am and 5pm on weekdays, or write to *The Office of the Ombudsman, PO Box 10152, Wellington 6143.*

Yours sincerely
Government Engagement and Support

Documents enclosed:

1. *Mental injuries*
2. *Mental injury due to physical injury*
3. *Treatment injury mental injury*
4. *Assessing a claim for mental injury*
5. *Timeframes to determine cover*
6. *Cover criteria for treatment injury*
7. *Work-related mental injury*
8. *Principles of effective three-point contact*
9. *Principles of goal setting in claims management*
10. *Completing initial three-point contact action plan*
11. *Principles of client centric services*
12. *Work-related mental injury and VR*
13. *Guidelines for managing and monitoring rehabilitation*

Mental injuries

Contact [redacted] Last review 01 Dec 2016 Next review 01 Dec 2017

Introduction

To be covered under the Accident Compensation Act 2001 (AC Act) a mental injury must be both:

- a personal injury. See the AC Act 2001, Sec ion 26
- a clinically significant behavioural, cognitive or psychological dysfunction. See the AC Act 2001, Section 27.

Rules

Personal injury

The following types of mental injury fall within the definition of a personal injury.

Mental injury	See the AC Act 2001....
Mental injury caused by physical injury	Section 26(1)
Mental injury caused by certain criminal acts	Section 21
Work-related mental injury	Section 21B

Clinically significant

For ACC to accept that a mental injury is "clinically significant" it must:
a. be diagnosed using one or more of the following standardised systems:

- Diagnostic and statistical manual of mental disorders - fourth edition - text revision (DSM-IV-TR)
- Diagnostic and statistical manual of mental disorders - fifth edition (DSM-5)
  - See DSM-IV-TR to DSM-5 for a summary of the differences between the two editions
- International classification of diseases - 10th Revision (ICD-10)
- Psychodynamic diagnostic manual (PDM)
- Diagnostic classification of mental health and developmental disorders of infancy and early childhood – Revised (DC:0-3R)

and

b. be diagnosed by a mental injury assessor who has:

- a qualification which meets at least level 8 (post-graduate) of a New Zealand Qualifications Authority (NZQA) recognised course or its equivalent, with a focus on:
  - assessment, classification and formulation in psychopathology
  - abnormal psychology
  - skills in using two or more models of therapeutic intervention
  - the consequences of: sexual abuse/assault; and/or physical injury; and/or workplace trauma
  - the use of psychometric tools (if using psychometrics)
- a minimum of two years' full-time equivalent post-graduate supervised clinical experience in one or more of the areas of mental injury covered by ACC
- met the supervision requirements of the professional bodies to which they belong
- met the cultural competency requirements of the professional bodies to which they belong.

Mental consequences

Under the 1972 and 1982 AC Acts, ACC provided cover for the physical and mental consequences of an injury or the accident. See:

- AC Act 1972, Section 2
- AC Act 1982, Section 2.

Note: If a person has cover for physical injuries under the 1972/82 Acts, it's not always clear whether ACC should treat a subsequent claim as one for 'mental injury' under the AC Act 2001, or for 'mental consequences' under the 1972/1982 Acts. If clarification is needed, please contact Legal Services.

Mental injuries to clients under 16

Children under the age of 16 are not eligible to have the impairment effects of a mental injury assessed, for lump sum only, unless there are compelling reasons. This is because long-term mental impairment effects cannot be accurately established.

See the AC Act 2001 Schedule 1, Part 3, Clause 57.

Mental injury assessments

A mental injury assessment must be carried out by a qualified assessor. See the AC Act 2001 Schedule 1, Part 3, Clause 58. ACC can ask clients to undergo assessments. See he AC Act 2001 Schedule 1, Part 3, Clause 58.

Deciding apportionment for lump sum or independence allowance for mental injury

So that we can determine lump sum or independence allowance entitlement, we consider the recommendations of a qualified assessor about what proportion of a client's mental injury is:

- related to conditions covered by ACC
- not related to conditions covered by ACC.

The assessor deducts any impairment that they think has not resulted from the covered injury from the whole of the person's impairment, which leaves the portion that is used to calculate their entitlement. This is known as apportionment.

For a client to be eligible, at least 10% of their impairment must be claim-related.

Resources for determining apportionment are the:

- Operational guidelines for impairment assessments for lump sum compensation and independence allowance
- ACC User Handbook to the AMA Guide to the Evaluation of Permanent Impairment 4th edition.

Mental injury due to physical injury

Contact [redacted] Last review 20 Apr 2015 Next review 20 Apr 2016

Introduction

In order for a mental injury from physical injury to be covered by the Accident Compensation Act 2001 it must be a personal injury. There are three main criteria for determining whether a mental injury qualifies as a personal injury:

- there must be cover for the physical injury claim
- there must be a clinically significant mental condition
- the physical injury must be a material cause of the mental injury.

Rules

Mental injury without physical injury

In most instances ACC does **not** provide cover for mental injury in situations where no physical injury is covered, eg:

- a mental injury to a person witnessing a car accident but who does not sustain physical injuries
- mental injury to a mother learning of her child's death.

However, there are some situations where ACC will provide cover for mental injuries not caused by a physical injury, eg:

- mental injuries caused by an AC Act 2001, Schedule 3 sexual offence are covered, even if there are no physical injuries involved
- work-related mental injuries caused by witnessing traumatic events are covered
- mental injuries caused by a non-covered physical injury sustained in a treatment context.

Mental injury due to physical injury

In most cases for the mental injury to have cover it must be caused by a physical injury, but the physical injury does not have to be the only cause of the mental injury.

In each case you must base your decision on the facts of the case and the mental injury assessment. In general, though, it should be clear from the mental injury assessment that the physical injury was a material cause of the mental injury. If you're unsure, contact Customer Service Technical Support (CSTS) for assistance.

Criteria for assessing mental injury caused by physical injury (MICPI)

A cover decision for a MICPI can often be considered 'simple' or 'complex'. The following table shows the criteria for simple and complex MICPI decisions.

A decision is...	when...

simple	either
	• the criteria for personal injury **have** been met and
	  • there is cover for the physical injury claim
	  • there is a clinically significant mental condition identified
	  • the physical injury is the material cause of the mental injury.
	• the criteria for personal injury **have not** been met, ie there is no cover for a physical injury claim, but the situation meets the criteria where ACC will cover mental injury not caused by physical injury.

complex	• it may not be clear if the mental injury is attributable to the physical injury • there is uncertainty about whether there is a clinically significant mental condition • there may be a combination of factors contributing to the mental injury including the physical injury • the injury report may require the expertise of the Complex Mental Injury Panel for interpretation or guidance, for example where the diagnosis is chronic traumatic encephalopathy. See Assessing a claim for mental injury • the request is for cover of schizophrenia as a mental injury caused by physical injury. These must all be referred to the Complex Mental Injury Panel (CMIP)

A decision is...	when...
	• a recommendation of a branch medical advisor (BMA), branch advisory psychologist (BAP), team manager or technical claims manager (TCM) is needed.

Traumatic injury circumstances

With injuries involving particularly traumatic circumstances, such as serious motor vehicle accidents or violent assaults, it may not always be clear whether the mental injury is attributable to the physical injury, the accident or the surrounding circumstances. The mental injury may have resulted from a combination of those factors.

Even if the mental injury was sustained in traumatic circumstances ACC is able to cover a mental condition if the mental injury assessor advises that the physical injury was a material cause of the mental injury.

Special case: Post-traumatic stress disorder

For a physical injury to be considered a material cause of post-traumatic stress disorder and other related disorders (PTSD), it is reasonable to expect the physical injury to have been either:

- serious
- accompanied by a threat of serious injury.

If the mental injury assessment report indicates the physical injury is a material cause of PTSD and other related disorders, it should reflect that the physical injury was serious or accompanied by threat of serious injury. Otherwise the report must include a detailed explanation of why the physical injury is considered a material cause.

The injury does not have to satisfy ACC's serious injury profiles to be regarded as serious for this purpose. The advice from the mental injury assessor is relevant to deciding whether the injury is serious as envisaged by the DSM IV multi axial criteria or one of the other diagnostic systems recognised by ACC in defining a clinically significant mental injury.

In general, ACC will consider a threat of serious injury to have been made in the circumstances set out in the following table.

Consider a threat of serious inury to have been made where...	and...
the injury is sustained directly from the threat, eg hit by person who verbally threatened harm, rather than incidentally to it, eg twisting ankle while running from perceived threat	the threat is direct rather than witnessed or inferred, and there was a real risk of it happening. The threat is considered direct and real if: • an explicit verbal threat of serious injury is made by someone known or reasonably believed to be capable of carrying it out • weapons are involved in an assault, even if not used to inflict the actual injuries • a clear threat is inherent in the nature of the event, eg, serious car accident, fire, animal attack, or war.

If claims involve a physical injury that occurred some time ago and the possibility of a mental injury is only now being identified, any evidence of a threat of serious injury having been made should generally exist from the time of the physical injury.

Treatment injury mental injury

Contact [redacted] Last review 03 Nov 2017 Next review 03 Nov 2018

Introduction

In 2012 the Court of Appeal decided that the Accident Compensation Act 2001 (AC Act) allows cover for a mental injury that has been caused by a non-covered physical injury, provided the mental injury meets the criteria for a treatment injury. See Monk v Accident Compensation Corporation [2012] NZAR 1.

This creates a new category of mental injury. Claims under these criteria are treatment injury mental injury (TIMI) claims.

This policy applies to new claims and the reconsideration of previously declined claims where the mental injury occurred after 1 July 2005.

Rules

For ACC to cover a TIMI, it must be a "personal injury that is treatment injury" (s 20(2)(b)) and meet the definition in s32.
ACC will cover a TIMI if:

- there is a clinically significant mental injury
- the mental injury has been caused by a physical injury, even though the physical injury is not covered
- the mental injury also meets the following treatment injury criteria:
  - it was caused by treatment
  - is was not a necessary part of treatment
  - is was not an ordinary consequence of treatment.

What is the difference between a MICPI and a TIMI?

If the physical injury that caused the mental injury is covered, the claim is for a mental injury due to physical injury (MICPI).

If the physical injury that caused the mental injury is not covered, the claim is for a treatment injury mental injury.

Determining cover

The Treatment Injury Centre investigates TIMI claims. Claims are assessed using a specific TIMI decision process and complex injury timeframes under section 57 of the AC Act.

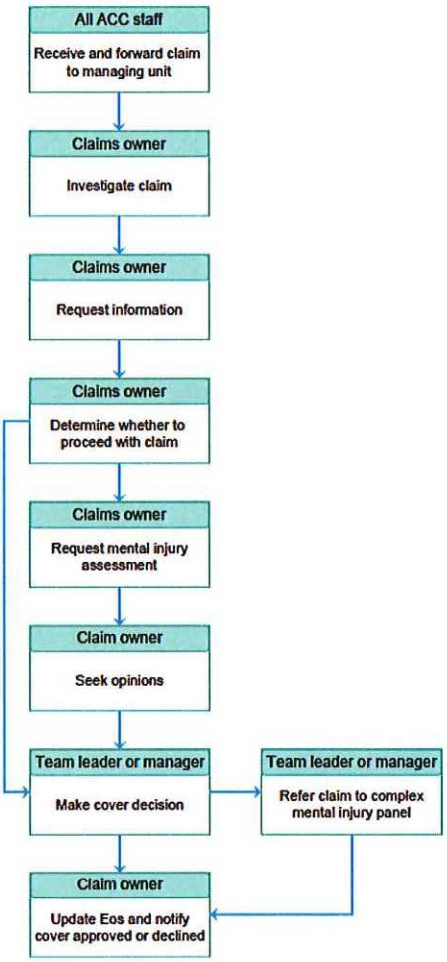
Cover decisions are made by the clinical advisor, Treatment Injury Centre, with advice and recommendations from the Treatment Complex Injury Panel.

Assessing a claim for mental injury

Claims management staff (CMS) use this process to investigate and make a cover decision for mental injury claims caused by physical injury (MICPI) or work-related mental injuries (WRMI).

Contact [redacted] Last review 27 Apr 2017 Next review 27 Apr 2018

Click on a shaded box for instruction details



Show all instructions

Receive and forward claim to managing unit

Responsibility

ACC staff

When to use

Use this instruction when a mental injury claim application has been received to forward it to the correct managing unit at ACC. For rules on what constitutes an application see Statutory timeframes for mental injuries.

Instruction

Step 1

Receive notification of mental injury via:

- ACC45 Injury claim form
- ACC18 Medical certificate

- ACC5774 Mental injury report – additional information form
- Letter from a general practitioner or a report from a provider that specifically suggests that the client has a mental injury requiring consideration of cover
- ACC54 Application form for lump sum/independence allowance.

Step 2

Check the claims, documents and contacts on the client's party record to see if:

- there is a claim for a physical injury
- there is a claim for a work-related traumatic event
- there are any case managed claims.

Step 3

Use the following table to decide who should investigate and decide on cover. The options in the following table are organised in order of priority, from highest to lowest. If more than one scenario applies, the highest one should be used:

If the claim ...	then forward the claim to...
is for a potential mental injury and likely to be a sensitive claim	the Sensitive Claims Unit
• is being case managed (includes at a Short Term Claims Centre) • has been case managed	a branch
• is new and identifies mental injury on the ACC45 Injury claim form • is a new ACC45 Injury claim form received for a mental injury associated with an existing physical injury claim • is an additional injury request received for a claim that is in the Registration Centre 'Actioned cases work queue' • has never been case managed	the Cover Assessment team within the Hamilton or Dunedin Service Centre
is a treatment injury mental injury where the treatment injury is a physical injury that is not covered	the Treatment Injury Centre

What happens next

Go to **Investigate claim.**

Back to process map ↑

Investigate claim

Responsibility

Case owner

When to use

Use this instruction when a claim has been received to gather all currently available information from existing ACC documentation, and to contact the client regarding the claim.

Instruction

Step 1

Review the claim to determine if it is for a mental injury (MI) caused by a physical injury (MICPI) or a work-related mental injury (WRMI). For the relevant criteria, see:

- Mental injury due to physical injury
- Work-related mental injury.

If cover is declined as the MI was not caused by physical injury or a traumatic event at work, check if it could be a treatment injury mental injury (TIMI). If it is, send it to the Treatment Injury Centre for assessment and cover decision.

Step 2

Determine if a decision can be made in the statutory timeframes. If not, send the client a CVR30 Time extension letter.

Step 3

If the claim is a held claim for mental injury caused by a treatment injury, then:

- create a task for the treatment injury claim owner and request that you are advised when a cover decision is made
- manage timeframes for making a cover decision
- if the physical injury claim is still held after four months, the mental injury claim must be declined as there is no cover for a physical injury. Go to **Make cover decision**.

Step 4

Generate a new ACC1517 Mental injury cover decision template form for the claim and complete with information from the ACC45 and other available information.

Step 5

Search all electronic and physical claim files for information relevant to the mental injury investigation, including:

- information about the covered physical injury
- psychological or psychiatric information in reports such as:
  - comprehensive pain assessments (CPAs)
  - vocational information and assessments conducted by psychologists

Ensure all relevant documentation on the physical files is copied and scanned to the managed claim file.

Step 6

Add a 'Contact' in Eos called 'Mental injury relevant documents' that lists the location of the electronic information.

Step 7

Prepare a copy of the Mental Injury phone template and call client.

If the client...	**then...**
cannot be contacted or declines to give consent to complete the phone template	send the client a: • CVR13 Acknowledge mental injury claim- claimant letter • PSYIS02 Mental injuries and ACC information sheet • ACC6300 Authority to collect medical and other records form • ACC4244 Mental injury client questionnaire form go to step 8

the client is contacted and gives consent to complete the phone template	• use the Mental injury phone template and save as a document.
	• send the client a:
	  • CVR13 Acknowledge mental injury claim- claimant letter
	  • PSYIS02 Mental injuries and ACC information sheet
	  • ACC6300 Authority to collect medical and other records form
	• go to step 8

Step 8

If the client...	**then...**
has a Work Related Mental Injury (WRMI)	• consider referring to the WRMI Early Intervention Service • go to step 9
doesn't have a Work Related Mental Injury (WRMI)	go to step 9

Step 9

Add a 'Contact' in Eos, and create a 'Follow-Up' task for two weeks to await the consent form and any requested information.

If you…	then…
receive the information	go to **Request information**
don't receive the info	there is insufficient information to support mental injury. Go to **Make cover decision** to make a decline claim

Back to process map ↑

Request information

Responsibility

Case owner

When to use

Use this instruction to request information from providers if they did not complete an ACC5774 Mental injury report – additional information form, and from employers, if needed.

Before you begin

When requesting medical information, make sure you include a form signed by the client giving ACC authority to collect relevant records from treatment providers.

Instruction

Step 1

If the provider that sent the initial claim for a mental injury did not send an ACC5774 Mental injury report – additional information form and/or the relevant medical notes, send the lodging provider a CVR14 Acknowledge mental injury claim - vendor, requesting that they provide the missing information.

Step 2

If the claim is for a work-related mental injury send a CVR15 Acknowledge witness work event – employer letter to the client's employer, or contact the employer by phone, and request the following:

- details of the incident or event
- copies of any workplace incident form or records
- copies of any relevant documentation, eg Workplace Health and Safety reports, council reports, witness statements, or police reports.

Step 3

Create a 'Follow-Up' task of two weeks for the return of the information.

If the information is…	then…
not received within two weeks	follow up with providers or employers
not received within four weeks	go to **Make cover decision** to make decision to decline claim as there is insufficient information.
received within timeframes	go to **Determine whether to proceed with claim**

Back to process map ↑

Determine whether to proceed with claim

Responsibility

Case owner

When to use

Use this instruction to confirm if the mental injury was likely caused by the physical injury or event.

Instruction

Step1

Check that all the required medical reports have been received and that you have sufficient information to proceed. Check if the client has any other existing claims that may hold relevant reports.

Step 2

Update the 'Mental injury relevant documents' contact previously saved, and the claim's ACC1517 Mental injury cover decision template.

What happens next

If...	then...
the client is to be referred for a mental injury assessment	go to **Request mental injury assessment**
there is enough information to make a cover decision	go to **Make cover decision**
there is not enough information to make a cover decision	go to **Request information from providers**

Back to process map ↑

Request mental injury assessment

Responsibility

Case owner

When to use

Use this instruction to request a mental injury assessment, and to review the assessment when it is received.

Before you begin

When requesting medical information, make sure you include a form signed by the client giving ACC authority to collect relevant records from treatment providers.

Instruction

Step 1

Call the client to tell them you will be arranging an assessment and confirm they are happy to be referred.

If consent to be referred is....	then...
given	go to step 2
not given	go to **Make cover decision**

Step 2

Select the type of assessor you require. If you're unsure whether to refer the client to a Clinical Psychologist or Psychiatrist for assessment, refer to a branch advisory psychologist (BAP). See When to refer for clinical advice and Referring for clinical advice.

If you're referring to a...	then...
Clinical Psychiatrist	• go to the contracted providers search and contacts list • select Clinical Psychiatric Services in 'Service Type' • contact the selected assessor to arrange an appointment • generate a purchase order using the appropriate code for Clinical Psychiatric Services • send the assessor a PSY11 Request for mental injury assessment – vendor - letter • go to step 3
	• go to the contracted providers search and contacts list

If you're referring to a...	then...
Clinical Psychologist	• select Psychological Services in 'Service Type' • contact selected assessor to arrange an appointment • generate a purchase order using the appropriate code for Psychological Services • send the assessor a PSY11 Request for mental injury assessment – vendor - letter • go to step 3 **Note**: a maximum of 16 hours is available for assessments completed by Clinical Psychologists. Consult with a BAP if you believe more than 16 hours may be required

Step 3

Generate and send the client a PSY11 Request for mental injury assessment – client letter and a PSYIS01 Mental injury assessments information sheet, and provide the client details of their appointment with the assessor.

Note: These are generated through the 'Documents' tab in Eos.

Step 4

Create 'Follow-Up' task of agreed timeframe for return of information.

If information is...	then...
not received within the timeframe	follow up with the providers
received within the timeframe	go to Step 5

Step 5

Review ACC4247 Mental injury assessment and confirm the validity of the information. Update the ACC1517 Mental injury cover decision template.

Step 6

If the report is...	then...
complete	go to **Seek opinions**
incomplete	go back to step 1

Back to process map ↑

Seek opinions

Responsibility

Case owner

When to use

Use this instruction to make a recommendation for cover and to obtain opinions from the:

- technical claims manager (TCM) within the appropriate unit or branch
- branch advisory psychologist (BAP) or branch medical advisor (BMA) if the BAP advice cannot be obtained within the required time frames.
- Branch or Service Centre team manager or leader.

Ensure the manager or advisor you're referring to has the appropriate delegation for the type of cover recommendation you require.

See Referring for clinical advice for instructions if you are referring to a BAP or BAM.

Note: If the client has an underlying Traumatic Brain Injury (TBI) or Dementia, please note this in the free text box of the task and transfer the task to the 'BAP Queue - Auckland' for allocation.

Instruction

Step 1

Create an 'organise internal referral' task that refers to the 'mental injury relevant documents Contact' previously saved, and a 'complete internal referral' subtask.

Step 2

Read all reports and supporting evidence.

Step 3

Provide a cover recommendation in the appropriate section of the ACC1517 Mental injury cover decision template.

Step 4

Allocate the 'complete internal referral' subtask to the TCM, BAP or BMA and TM or TL.

What happens next

The TCM, BAP or BMA make their recommendations and send the task to the TM, TL or requestor. Go to **Make cover decision**

Back to process map ↑

Make cover decision

Responsibility

Team leader (TL) or team manager (TM).

When to use

Use this instruction to make a cover decision or referral to the Complex Mental Injury Panel (CMIP).

Note: All claims for cover of schizophrenia as a mental injury caused by physical injury must be referred to the CMIP.

Instruction

Step 1

Review all information, including the advisor recommendations and consider whether there is sufficient information to make the mental injury cover decision or referral.

Step 2

If...	then...
there is enough information to make a decision	go to step 3
there is not enough information to make a decision	go to **Request mental injury assessment**
there isn't enough information to make a decision and the client hasn't given consent to be referred for an assessment	go to Update Eos and notify cover approved or declined

Step 3

If...	then...
the claim is for a work-related mental injury	go to **Refer claim to complex mental injury panel** for a decision
the claim is for a complex mental injury from physical injury (MICPI)	go to **Refer claim to complex mental injury panel** to get advice
the claim is for a simple MICPI	go to Step 4

Step 4

Make cover decision.

What happens next

Go to Update Eos and notify cover approval or decline

Back to process map ↑

Refer claim to complex mental injury panel

Responsibility

Team leader (TL) or team manager (TM).

When to use

Use this instruction to prepare a claim and recommendation for referral to the Complex Mental Injury Panel (CMIP), and receive their decision or advice.

Instruction

Step 1

Provide your recommendation to the CMIP in the appropriate section of the ACC1517 Mental injury cover decision template.

Step 2

Prepare the referral to the CMIP, ensuring that ACC1517 Mental injury cover decision template is fully completed and all relevant documents and reports are attached.

Step 3

Create an internal referral task in Eos and send it to the Operations Support department work queue.

Step 4

When the task is returned, review the panel decision or advice on cover for mental injury.

What happens next

If...	then...
the claim was a complex mental injury from physical injury and advice was provided	go to Make cover decision
the claim was a work-related mental injury and a decision was made	go to Update Eos and notify cover approved or declined

Back to process map ↑

Update Eos and notify cover approved or declined

Responsibility

Branch case manager or Service Centre claims officer

When to use

Use this instruction when the cover decision has been made.

Instruction

Step 1

If the decision is to...	then...
approve the claim	• change the 'Cover Status' to 'Accept' • change the 'Cover Status Reason' to 'Criteria for Cover are met' • send the client a CVR51 Approve cover mental injury letter. • go to step 2

decline a work-related mental injury claim	• change the 'Cover Status' to 'Decline'
	• change the 'Cover Status Reason' as relevant, usually one of the following:
	  • No Mental Injury
	  • Exclusionary Criteria Apply
	  • Injury Not Result of Accident
	• update the 'Cover Status Change Reason' with more details if required
	• contact client to inform them of decision, and explain the reasoning
	• send the client a CVR999 Cover decline decision - client letter
	• this process ends

	• change the 'Cover Status' to 'Decline'

If the decision is to...	then...

decline a mental injury caused by physical injury claim	• change the 'Cover Status Reason' as relevant, usually one of the following:
	  • No Mental Injury
	  • Exclusionary Criteria Apply
	  • Injury Not Result of Accident
	  • No Physical Injuries
	• update the 'Cover Status Change Reason' with more details if required
	• contact client to inform them of decision, and explain the reasoning
	• send the client a CVR999 Cover decline decision - client letter
	• this process ends

Step 2

If the mental injury caused by physical injury was lodged as a new claim and it is accepted then link the claim to the physical injury claim as a duplicate.

Step 3

Determine if the claim requires transfer for case management.

If case management is...	then...
required	• return to the managing team • this process ends
not required	this process ends

Back to process map ↑

Timeframes to determine cover

Contact [redacted] Last review 31 Jan 2013 Next review 01 Nov 2013

Introduction

ACC operates under strict legislative timeframes for making cover decisions. If we don't meet these timeframes, a client's cover decision is deemed in their favour under the AC Act 2001, Section 58.

Rules

Non-complicated claims

We must determine cover within 21 days of lodgement for claims that are considered non-complicated.

If there is not enough information to make a cover decision, we must inform the client that a decision cannot be made and the timeframe is being extended up to four months from the date of lodgement. Use the CVR30 Time Extension - advise - claimant (42K) letter.

We must make a final decision within four months of the claim being lodged.

See of the AC Act 2001, Section 56.

Complicated claims

The following claims are considered complicated:

- personal injury caused by a work-related gradual process, disease or infection
- treatment injury
- claims for cover lodged 12 months after the date of accident (late claims)
- mental injury caused by certain criminal acts (sensitive claims)
- work-related mental injury.

We must make a cover decision within two months of a complicated claim being lodged. If we can't make a decision we must inform the client that we're extending the timeframe up to four months from the date of lodgement. Use the CVR30 Time Extension - advise - claimant (42K) letter.

See AC Act 2001, Section 57.

Additional extension

It's possible to extend the timeframe for a complicated claim cover decision by up to nine months from the date the claim was lodged. The client must agree to this further extension by signing the form attached to the CVR31 Time Extension - request - claimant (88.5K) letter.

We must make a final decision within nine months of the claim being lodged.

Cover criteria for treatment injury

Contact [redacted] Last review 31 Oct 2017 Next review 31 Oct 2018

Introduction

The AC Act 2001 was amended replacing the provision for medical misadventure with treatment injury. The treatment injury provisions apply to all claims lodged for the first time on or after 1 July 2005. For claims lodged before this date see Cover criteria for medical misadventure.

A treatment injury occurs when a person suffers a personal injury when undergoing treatment by a registered health professional (RHP). See Scenarios for treatment injury.

Rules

You must consider all of the following factors when making a treatment injury cover decision:

- the client must have suffered a personal injury
- the injury must have happened in the context of treatment
- there must be a clear causal link between the treatment and the injury
- the injury must not be a necessary part or ordinary consequence of the treatment
- the claim must not fall under any of the treatment injury exclusions from cover.

Date of injury

The date on which a person suffers a treatment injury is the date on which the person first seeks or receives treatment for the symptoms of that personal injury. This date applies, even if it was not known at the time the treatment was first sought or received for the symptoms, that previous treatment was the cause of the symptoms.

We determine the date that a client first sought or received treatment by taking the advice of the treatment provider and any other medical experts who lodged the claim. This date must be supported by clinical records.

See the AC Act 2001, Sections 38 and 53.

Clinical trials

We can accept cover for a treatment injury sustained during a clinical trial under either of these conditions:

- the client did not agree in writing to participate in the trial
- an ethics committee, which was approved by the Heath Research Council of New Zealand or the Director General of Health, approved the trial and was satisfied that is was not to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled.

Third party infections

When an original infection is covered as a treatment injury, we'll also accept cover when a person passes on their infection to anyone else.

See the AC Act 2001, Sections 32(7) and 18A.

Work-related mental injury

Contact [redacted] Last review 22 Jun 2016 Next review 22 Jun 2017

Introduction

ACC has been able to consider claims for work-related mental injuries since 1 October 2008. We can accept claims for cover where a person suffers a clinically significant mental injury caused by a traumatic work related event.

Rules

Mental injuries not covered by this include:

- exposure to traumatic events outside of work
- gradual onset workplace stress.

The work-related mental injury must have been caused by a single, sudden event that occurred in a client's employment.

Unlike other mental injury claims, a work-related mental injury does not need to be linked to a physical injury. If the client receives a physical injury you should also consider whether the claim for cover is for a mental injury resulting from a physical injury as the two claims have different criteria and dates of injury. This will depend on the content of the mental injury assessment. Seek advice from your Team Manager if you are unsure.

> **Example:**
> A bus driver in Manukau swerves to avoid hitting a pedestrian who deliberately steps in front of the bus. The pedestrian is killed instantly when they are clipped by the front end of the bus. As the bus driver is suffering from severe clinical depression because of this event his general practitioner lodges a claim for a work-related mental injury.

Criteria for work-related mental injury

The criteria for determining if a claim for work-related mental injury can be accepted for cover are:

The client is diagnosed with a clinically significant mental injury

In order for the mental injury to be covered, it must be diagnosed as being a clinically significant behavioural, cognitive, or psychological dysfunction. Temporary distress that constitutes a normal reaction to trauma is not covered. In order for ACC to accept a claim the diagnosis must be made by a qualified mental injury assessor following a standardised system. For more information, see Mental injuries.

The mental injury has a causal link to a work-related event

For a work-related mental injury to be covered, it must be caused by a single, sudden event that occurred in a person's place place of employment.
The mental injury assessor's report should identify whether the event was a material or substantive cause of the mental injury.

The Injury is caused by a single event

For a mental injury to be covered, the injury must be caused by a single event. A series of events that arise from the same cause or circumstance can still be considered a single event. In these situations take care to ensure that all parts of an event are clearly identifiable and occur at a precise point in time. This is different to a gradual process, which refers to a series of recurring events over a longer period that have a cumulative effect.

The event can reasonably be expected to cause mental injury

In order for the mental injury to be covered, it must be caused by an event that could reasonably be expected to cause mental injury to people generally. Events that could reasonably be expected to cause mental injury would:

- provoke extreme distress, horror or alarm in almost everyone
- be outside the normal range of human experience (normal human experience would include bereavement, business loss, and divorce).

In cases where the event is significant, there will usually be lots of information that can be gathered from workplace incident reports, and police or emergency services reports, as well as a Department of Labour investigation. The more information that can be obtained, the more robust the cover decision will be.

The event is sudden in origin

In order for the mental injury to be covered, the event that caused it must be sudden in onset. A sudden event is one that occurs quickly with little or no warning, but the event itself may last a short or longer time. An event lasting a short time might include a drive-by shooting, while an event lasting a longer could be a hostage situation lasting many hours. Irrespective of their duration, both are sudden events.

The event was experienced, seen or heard

In order for the mental injury to be covered the client must directly experience the event that caused the mental injury. The client must be in close physical proximity to the event and see or hear it in order to experience it.
A person cannot experience an event directly if they:

- see it on television, including closed circuit television
- see pictures of, or read about it, in the news media
- hear the event on radio or by telephone
- hear about the event from radio, telephone, or another person.

In most cases, a person will see an event directly. In cases where a person experiences the event through hearing it, for example from a room adjacent to that where the event took place, extra care will be required.

If a claim is lodged as a result of witnessing an event on a closed circuit television by a person who is required to provide video security surveillance as part of their employment, seek advice from your Team Manager. The Team Manager can obtain assistance from Customer Service Technical Support if necessary.

The direct outcome of a sudden event

If the person does not directly witness the event as it occurs, they can still be eligible for cover for a mental injury if they are involved in, or witness, the direct outcome of the event.
To be directly involved in, or witness, the outcome of a sudden event means the person must be physically present at the scene of the event.
A person may be at the scene of the event and:

- provide medical assistance
- provide emergency response assistance
- be part of a rescue or clean up operation.

Principles of effective three-point contact

Contact [redacted] Last review 12 Jul 2017 Next review 12 Jul 2018

Introduction

The purpose of three point contact is to:

- make early contact with the client, employer and medical practitioner to establish rapport
- follow up with the client after any service needs assessment (SNA)
- respond to any requests the provider made on the ACC45 for us to contact them or to provide assistance for the client
- understand the client's circumstances
- confirm the claim's complexity
- identify whether cover or entitlement needs to be investigated further
- set initial expectations about return to work (RTW) or return to independence (RTI)
- gather enough information to establish an initial action plan
- explain the different roles and the client's rights and responsibilities.

Many clients will have been contacted during a service needs assessment, so it is important to not excessively revisit topics already covered in the SNA .

Outcome

After you have made contact with all the parties, you should expect that:

- all parties clearly understand the expectations and next steps
- you have identified and clearly documented the complexity of the client's current circumstances and any barriers to recovery
- you have confirmed the injury diagnosis
- you have identified and followed-up any issues with the cover decision
- you have identified any pre-injury work and/or social activities
- you have identified any treatment or rehabilitation already undertaken
- you have recorded ACC's actions and added the relevant contacts to the claim file.

What to consider

Preparing for effective contact

Your contact with the key parties can have a real influence on the ongoing success of the client's rehabilitation. Therefore, it is essential that you prepare well before you make contact.

Checklist for effective contact

All claims	Ask yourself...
Review the description of the accident and injury	• Do you have any concerns about the cover decision? • What questions should you ask to confirm cover? • Is the diagnosis accurate? Have we used the correct fund code?
Review: • the client's job type • the service needs assessment (SNA) 'Initial Client Interview Script' script • any medical reports or records on the file	• Are there any duties that the client could be doing?
Review the cover flags and claim complexity indicators	• Do the flags and indicators reflect the complexity of the claim? (See Claims complexity)
Review the medical certificates for current certified capacity for work, for earner clients	• Is the duration of incapacity certified reasonable, considering the injury description and work type? • Is it possible that the client is going to be fit for their pre-injury employment?

All claims	Ask yourself...
	• Has the client said how long they expect to be incapacitated and how does this relate to the certified duration?
Review the client's claim history in Eos and/or the expected claim outcome (ECO) tool to identify any previous: • similar injuries • weekly compensation • relationship issues with ACC	
If applicable, review the relevant Rehabilitation Pathway information	

Claims transferred to branch from STCC

In addition to the above, you should also review:

- the rationale for transferring the claim to case management
- any interventions provided to date and what the outcome has been, eg Stay At Work reports
- the current action plan on file and any outstanding issues
- whether the claim would benefit from a review by an expert, eg Branch Medical Advisor, Technical Claims Manager, or Panel
- whether the employer has raised any issues that need following up.

Consider contacting the previous case coordinator if any of the information is unclear

Guidelines for effective client contact

Your first contact with the client is key to building rapport and establishing a good ongoing relationship. Remember, the client may already have been contacted byACC for a service needs assessment or other interview so it is important you are familiar with information that has already been gathered. When you speak with the client remember:

- be respectful
- speak clearly and don't use ACC jargon
- listen to what the client says and ask questions to clarify any points. Summarise what you have heard
- check that the client understands what you are saying
- be clear about what you can and can't do to help
- acknowledge the client's concerns
- be positive and forward thinking
- if the client has difficulties with English or there appear to be barriers related to cultural issues, consider referring the claim to the Cultural Capability team to assist your communication with them.

What to cover in your conversation

Depending on the circumstances, you should:

- explain your role and what the client can expect from ACC
- acknowledge any previous contact by ACC, eg a SNA , and explain why the claim has been transferred to the STCC or branch
- take care not to revisit information already provided during a SNA. However, if it's appropriate (eg to check or expand on SNA details or to build rapport), consider:
  - asking the client what they understand about their injury. If there is delayed incapacity, ask what happened between the time of the injury and the onset of the incapacity
  - asking about the treatment they have received and how successful it has been so far
  - asking the client how they think things are going and what their expectations for recovery are
  - asking if they have any medical conditions or are taking medication that may affect their recovery
  - asking how the client is managing at home and whether there are any natural supports available
  - finding out what non-work activities they do and if these have changed since the injury
  - asking the client what they normally do at work and whether there are alternative duties they could do
  - asking if they have been in touch with their employer and do they have any concerns about returning to work

    - managing the client's expectations about weekly compensation, including what can be used to calculate earnings
- tell the client that you will also be contacting their employer and medical provider. Be clear that you will respect their privacy and ask for their consent to contact the other parties
- explain the client's rights and responsibilities
- arrange a face-to-face meeting with the client and discuss what this will include if you are a Branch case owner
- tell the client what will happen next
- Advise that the support of a stay at work provider may be used to assist them to get back to work safely.

Identifying possible barriers

See: SNA/Initial contact guidelines table.

Guidelines for effective employer contact

Your contact with the employer is also critical, particularly if the client has, or will have, some ability to return to work (RTW) if temporary adjustments can be made at the workplace.

If the claim has been assigned for case management because of obstacles at the workplace, you will need to be sensitive. However, the best outcome is to protect the client's ability to RTW, so it is important to put in the effort right from the start.

Make sure you speak to the person at the workplace who can make decisions about offering adjusted duties. They may not understand what may be possible for supporting the client and their recovery at work.

What to cover in your conversation

Depending on the circumstances, you should:

- explain your role and ask them to get in touch if they have any questions or issues
- find out whether they have been in touch with the client and whether they have any concerns. If they do have concerns, think about possible solutions, such as the support of a Stay at Work (SAW) provider, unpaid work trial funded by ACC or case conference
- explain that is really important for the client to keep in touch with them and that people recover much quicker if they can undertake some level of work. Make sure you acknowledge the employer's role in supporting a RTW
- discuss employment security and whether work would be available if the client wasn't injured. How will they cover the client's absence?
- ask the employer for the specific job tasks that the client performs and details about the physical environment. Check that this matches what the client has told you
- discuss the usual recovery pathway and length of time of work for this type of injury and work type
- ask if the employer wishes to be involved in developing the individual rehabilitation plan (IRP) if you are a Branch case owner
- explain what will happen next.

Identifying possible barriers

See: Employer Contact Guidelines

Privacy considerations when contacting employers

The employer needs to understand what their worker can and cannot do and when they are expected to improve. Let the employer know the usual recovery pathway and duration of work disability for this type of injury. Keep this at a general level, and be aware of client privacy considerations.

If relevant, provide some general information about normal recovery timeframes.

When the injury is non-work related, you are only permitted to provide information about the client and injury that is relevant to arranging a RTW.

Although the injured worker may choose to talk with their employer about these details, it is not necessary to discuss:

- the cause of the injury
- non-injury factors or medical conditions the client has
- other claims the client may have had.

Guidelines for effective medical practitioner contact

Make contact with the relevant treating provider, eg specialist or GP. You may also want to contact other providers, such as the physiotherapist. Respect the provider's time by being prepared before making a telephone call, asking for relevant information and taking care that you are not asking for information already on file.

Understand that every practice is different and that it is important to know how they like to be contacted and who the best person to contact at the practice is.

What to cover in your conversation

Depending on the circumstances, you should:

- introduce yourself and explain that you want to support their patient's rehabilitation
- confirm or clarify the current diagnosis and ask about the treatment plan. If necessary, ask for the relevant clinical notes
- discuss the expected recovery timeframes and the expected outcome. If these are different to what you expected, ask why the recovery is delayed, eg medical issues we were unaware of
- tell the medical provider what job tasks the client performs and details about the physical work environment
- ask whether they support some level of RTW, either now or in the future if you can make a plan for this. Refer to any RTW plans already made with client and/or employer

Branch case owners should also ask if the medical practitioner wishes to be involved in developing the individual rehabilitation plan (IRP).

Principles of goal setting in claims management

Contact [redacted] Last review 05 May 2015 Next review 04 May 2016

Introduction

Quality planning from the start of managing a claim ensures the best possible outcome for both the client and ACC. It sets the process up to run smoothly and provides structure to claim management.

Part of the planning process is goal setting. Goals inform the action plan and individual rehabilitation plan (IRP).

What to consider

Why do we need goals?

- Goal setting helps the case management process to run smoothly for all involved
- Collaborative goal setting ensures that we listen to the client and determine whether their expectations about what ACC can provide are realistic and correct
- Goal setting educates the client about their rehabilitation and the services ACC provides
- Goals focus attention on activities to restore the client's pre-injury function
- Goals help focus both the client and the case owner on the same result.

Goals must be client-centric. Client-centric goals consider bo h the needs of the client and the services ACC provides.

Appropriate goals need to take into account ACC Expected Duration and the claim's complexity. For most claims the initial RTW Target Date will be close to the Optimum duration date.

Claim complexity can have a big impact on the progress of a claim. A low complexity claim is one where recovery is expected to be straightforward. A high complexity claim is one where significant rehabilitation and time is expected to be required.

Helping the client set their goals

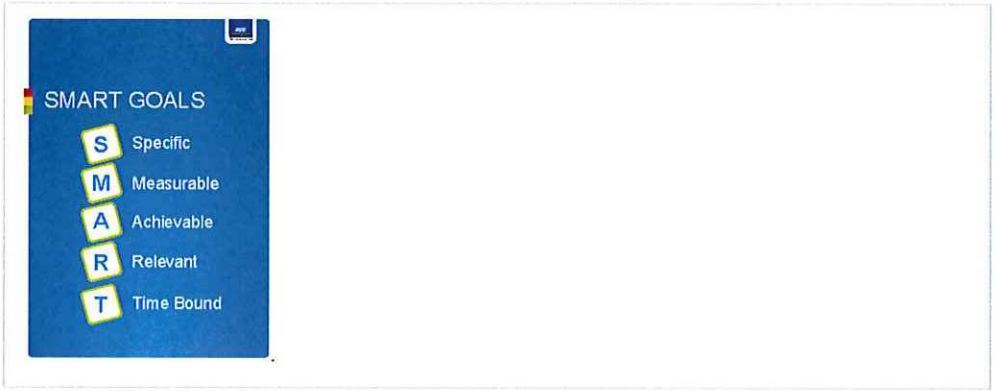
Read the information on file and seek input from the parties involved in the client's rehabilitation, eg GP, family, physiotherapist etc.

Match the client's needs with the appropriate ACC services, taking into account their natural supports.

Set SMART goals with the client and any other appropriate parties, eg GP.

Review the goals at each contact with the client and whenever you receive new information about the claim.Remember the goals are about what can or could be achieved and are designed to motivate the client towards better outcomes, they're not designed to passively track the final outcome. Make sure you update the SMART goals when and where appropriate.

SMART goals



Specific: "I will go back to my usual work…"

Measureable: "…fulltime"

Achievable: "The expected return to work date allows for 2 weeks of physiotherapy strengthening and mobilisation following cast removal, which is realistic given the fracture type and work type."

Relevant: "Allows time for rehabilitation for sustainable return to usual work".

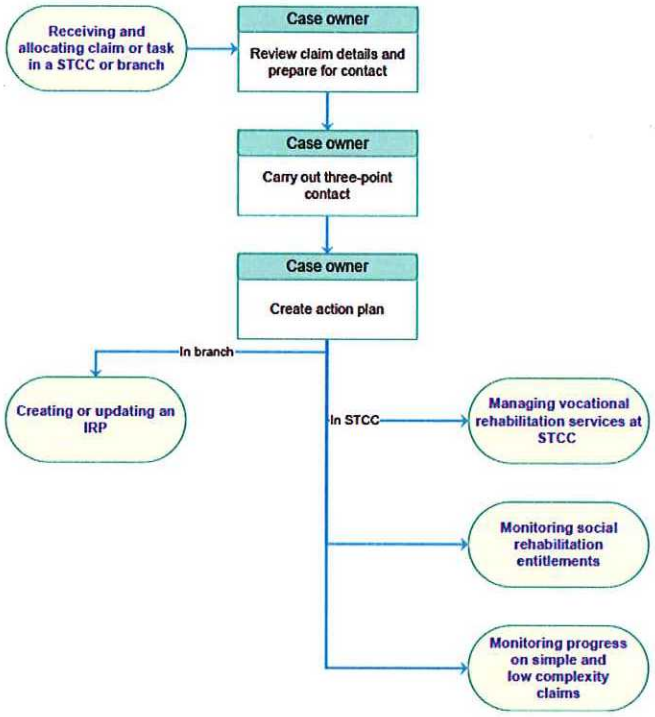
Time bound: "Return to work date 02/06/2013".

Completing initial three-point contact and action plan

This process is used to prepare for three-point contact and create an action plan when case owners receive a new claim.

Contact [redacted] Last review 26 May 2016 Next review 26 May 2017

Click on a shaded box for instruction details



Show all instructions

Review claim details and prepare for contact

Responsibility

Case owner

When to use

Use this instruction when you are allocated a new claim and need to prepare for three-point contact and create an action plan. You must complete your three-point contact within two working days of being allocated the claim.

Instruction

Step 1

Review the information about the client's injury, including the cause of injury and why it was allocated for management. Check:

- the current claim details
- the 'Single client view' (SCV) in InFact
- the party record
- the current claim details.

Step 2

If there is a service needs assessment (SNA) Initial Client Interview Script completed on the claim, review it to identify:

- cover flags
- indicators of claim complexity, eg 'N65 client not confident or motivated to return to work'
- reasons behind the claim complexity indicators
- rehabilitation/compensation needs.

Step 3

If there is an alert on the client's claim file identifying that the client has another open claim, then follow the current process for managing clients with more than one open claim. .

Step 4

Review the cover decision and check that the correct fund code has been recorded.

Step 5

Check that the correct claim complexity has been applied/assigned.

Step 6

Familiarise yourself with the claim and prepare for three-point contact. See Principles of effective three-point contact.

What happens next?

Go to **Carry out three-point contact**.

Back to process map ↑

Carry out three-point contact

Responsibility

Case owner

When to use

Use this instruction when you have reviewed all the relevant claim information and are ready to make contact with the client, medical practitioner and employer. You must complete your three-point contact within two working days of being allocated the claim. The two days start from the date transferred and allocated to STCC staff, not from the original date of allocation.

Before you begin

Familiarise yourself with the Principles of effective three-point contact.

Instruction

Step 1

Check for an open or closed AUTO 'Contact Provider' task in Eos.

If the provider has ...	and there is...	then...
selected 'contact me' on the ACC45	an AUTO 'Contact Provider' task on the claim	• contact the provider first • complete and close the open AUTO 'Contact Provider' task using the Do a task process • add a contact to the claim file in Eos • go to step 2
not selected 'contact me' on the ACC45	**no** AUTO 'Contact Provider' task on the claim	• complete your three-point contacts in any order, as appropriate or depending on availability. If you are unable to make contact within 2 working days because of your own unavailability, you must arrange for someone else in the team to make contact • go to step 2

Step 2

Check for an open or closed AUTO 'Assistance Required' task in Eos.

If the provider has...	and there is...	then...

If the provider has...	and there is...	then...
selected 'assistance required' on the ACC45	an AUTO 'Assistance Required' task on the claim	• establish the type of assistance the provider believes would be appropriate and incorporate this in your claim planning • complete and close the AUTO 'Assistance Required' task using the Do a task process • go to step 3
not selected 'assistance required on the ACC45	is **no** AUTO 'Assistance Required' task on the claim	go to step 3

Step 3

If you are a case owner...	then complete in any order...

from STCC	• if a service needs assessment (SNA) ' Initial Client Interview Script' (666k) has not been done, complete the STCC/branch 'client contact script'
	• if a SNA 'Initial Client Interview Script' has been done, complete the STCC/branch 'client contact script' but:
	  • use the information from the SNA to establish rapport with the client
	  • take care to not excessively revisit topics covered in the SNA
	  • confirm that the claim complexity and any cover flags are correct
	• if weekly compensation is required, then:
	  • complete the WC script
	  • creating a 'Setup weekly comp entitlement' task
	  • creating a 'Non standard WC setup' eForm, if needed
	  • the Weekly Compensation team will set up weekly compensation
	• complete the 'Return to work' script with employer for their employee clients
	• you may also choose to make contact with he provider, if appropriate
	• go to step 4

from Branch	• if a service needs assessment (SNA) 'Initial Client Interview Script' has not been done, record a contact in Eos or complete the STCC/branch 'client contact script'
	• if a SNA 'Initial Client Interview Script' has been done, record a contact in Eos or complete the STCC/branch 'client contact script' but:
	  • use the information from the SNA to establish rapport with the client
	  • take care to not excessively revisit topics covered in the SNA
	  • confirm that the claim complexity and any cover flags are correct
	• if weekly compensation is required, then:
	  • complete the WC script
	  • creating a "Setup weekly comp entitlement'task
	  • creating a 'Non standard WC setup' eForm, if needed
	  • the weekly compensation team then set up weekly compensation
	  • complete the 'Return to work' script for employed or self employed clients or record a contact in Eos
	  • go to step 4

Step 4

Based on the information gained during the SNA and your three point contact, identify a target goal for the claim.

Step 5

Identify any key events and milestones to help the client achieve their goal and timeframes for these. Identify and agree the actions the client needs to complete to meet these milestones.

What happens next?

Go to Create action plan

Back to process map ↑

Create action plan

Responsibility

Case owner

When to use

Use this instruction when you have completed your three-point contact with the client, lead health practitioner and employer and need to create an action plan.

Before you begin

Familiarise yourself with the policy on Action plans and the Principles of quality action planning.

Instruction

Step 1

Open the 'Action Plan' sub-tab of the 'Managing' tab in Eos.

Step 2

Open the 'Rehabilitation Path' section in Eos and select a suitable rehabilitation path for the client.

Step 3

Enter the date that your client aims to achieve their rehabilitation path by into the 'Target date' field.

Step 4

Explain how the client will achieve the rehabilitation path within the timeframe you have set in the 'Results Rationale' box.

Step 5

Open the 'Action Plan' and complete all relevant sections of the action plan.

If the client is...	then complete...
an earner	• client section • employer section • provider section The 'Other' section is optional. Only use the 'Other' section for information that does not fit into the other sections, eg cover confirmation, duration dates
a non-earner	• client section • provider section The 'Other' section is optional. Only use the 'Other' section for information that does not fit into the other sections, eg cover confirmation, duration dates

Step 6

In the 'Plan and Rationale' field for each section, enter the action(s) that the client and case owner will undertake to achieve their rehabilitation goals. Include current actions as well as planned actions.

Step 7

In the 'Review date' field for each section, enter the date that you will review this section of the action plan.

Step 8

Add a 'Monitor Rehabilitation Action task'. The contents of each 'Plan and Rationale' field will automatically populate into the task description and the nearest review date will automatically populate as the task's 'Target date'.

Step 9

Review and set up any other immediate entitlements if needed, eg weekly compensation, appropriate interventions and/or purchase orders.

What happens next

If...	then...

If...	then...
the client needs an IRP, ie the claim is in a branch	go to Creating or updating an IRP and consider the actions listed in the action plan
the client does not need an IRP, ie the claim is in a STCC	continue with standard claim management until the 'Monitor Rehabilitation Action task' becomes due or you receive new information. To manage the claim go to either: • Monitoring social rehabilitation entitlements

Back to process map ↑

Principles of client centric services

Contact [redacted] Last review 12 Jul 2017 Next review 12 Jul 2018

Introduction

Client-centric claim management places the client at the centre of all of the actions on a claim. It ensures that all decisions you make are in the best interests of the client and their journey to recovery and rehabilitation. This includes everything from the tone of voice you use when speaking with the client to understanding their injury and how it relates to their ability to work.

What is client-centricity?

Client-centricity means keeping the needs of the client in mind in all:

- communications
- planning
- goal setting
- decision making
- referrals.

Why be client-centric?

Having a client-centric approach will result in:

- improved client trust, confidence and satisfaction
- active participation in rehabilitation
- consistently high quality outcomes
- achieving a balance between providing the best outcome for clients and sustainability
- increased job satisfaction working for a well-respected organisation with a reputation for fair and timely business practises
- better cooperation between the client and case owner, which is key to effective rehabilitation
- a positive client experience.

Does being client-centric mean saying YES to every request?

No. Client-centric claim management provides the right intervention at the right time. Keeping the client at the centre of rehabilitation ensures we provide the correct service.

Example:

The client makes a request for a wheelchair when their doctor has specifically advised them to use crutches while their fractured ankle is in a cast. Putting the client at the centre of this decision means understanding that active mobilisation prevents blood clots, increases general muscle tone and helps maintain independence.

You should decline to provide the wheelchair, but deliver the decision with a suitable rationale in a timely and respectful manner.

Example:
The client asks for something that ACC does not provide according to legislation, such as weekly entitlement for non-injury related incapacity, eg conjunctivitis. A client-centric "no" answer to this request involves explaining the reason for declining the request in terms that the client can understand, in a timely and respectful manner.

Keeping your relationship professional

It is important to keep your relationship with your client professional. Being professional takes willingness, skill and awareness of others. If you are tired, stressed and under pressure it is more difficult to develop and maintain a professional relationship. ACC provides customer service training to assist you to achieve the appropriate level of professionalism when dealing with clients (see Lime).

The Code of ACC Claimant's Rights describes the expected client-centric values and behaviours. This includes:

- putting people first, injuries second
- telling the truth and keeping promises

- helping clients receive their entitlements
- ensuring our behaviour is professional in every respect
- setting up working relationships with clients and staff that enhance individual self-esteem
- being sensitive to culture, values and beliefs
- making decisions based on facts, not assumption, bias or prejudice
- communicating in a clear, simple and helpful manner, to minimise the potential for misunderstanding.

How do you know when claim management is client-centric?

You'll know that you have achieved a client-centric approach because:

- there will be fewer complaints about ACC staff
- there will be fewer litigious reviews
- claim management will focus on rehabilitation rather than process
- there will be a lower number of long term claims
- there will be an improvement in treatment and vocational provider service outcomes as the right service has been provided at the right time
- there is improved public trust and confidence in ACC.

Work-related mental injury and VR

Contact [redacted]

Effective From 20 Mar 2012 Effective To 28 Mar 2012

Introduction

Clients who have cover for a work related mental injury (WRMI) receive the same entitlements that apply to any other injury, including vocational rehabilitation (VR).

Rules

You must identify all viable VR options for the client as early as possible.

You must determine if there are any likely barriers to the client returning to either their pre-injury employment or a different job with their pre-injury employer.

Review the psychiatric assessment and Contact Centre initial interview script and note:

- anything that indicates the client may not want to return to their pre-injury work, eg yellow flags or comments
- the level of support the client needs, as indicated by the client, health providers, employers or other sources.

Focus on the 'maintain employment' pathway, using any appropriate early vocational interventions.

You must closely monitor the client's progress towards the agreed VR outcome:

- if the client is unlikely to maintain or return to their pre-injury employment you must identify all alternative employment options, eg a different role with the same employer
- if the client is attempting to maintain their employment but likely to lose their job use the maintain employment interventions and the obtain employment pathway initial occupational or initial medical assessments (IOA/IMA) to determine their future needs
- if the maintain employment pathway and interventions are not successful try the obtain employment or 'regain or acquire vocational independence' pathways
- if the client is unable to return to their pre-injury employment arrange an IOA and IMA to determine appropriate interventions and the next steps in their VR.

The client must agree to the VR pathway before you update the rehabilitation plan.

Ongoing rehabilitation

You must aim to achieve the best possible rehabilitation outcome for the client.

You must look at all options when deciding which social and vocational rehabilitation entitlements will best support the rehabilitation outcome.

Look at all assessments and reports, including:

- the initial psychiatric assessment report
- any additional psychological services and counselling reports
- any social or vocational rehabilitation assessment reports.

You must identify any potential or actual risks that may delay rehabilitation.

Use available supports to manage the claim and develop the most appropriate rehabilitation strategies. Supports may include:

- a case conference with all parties, including General Practitioner (GP) and employer, to agree on the rehabilitation pathway
- getting advice from:
  - your team manager (TM), technical claims manager (TCM), the branch medical advisor (BMA) or branch psychology advisor (BPA)
  - Customer Service and Technical Support (CSTS), via your TM or panel, if the VR issues are complex or technical
  - the manager Psychology and Mental Health, through the BMA or BPA
- asking the branch multi-disciplinary panel to monitor the claim.

Guidelines for managing and monitoring rehabilitation

Contact [redacted] Last review 06 Nov 2017 Next review 06 Nov 2018

Introduction

Managing and monitoring the rehabilitation progress on a claim is one of the most important parts of your role as a case owner. This starts with proactively maintaining contact with the client, their employer and the treatment and rehabilitation providers.

The relevant process to refer to is Managing and monitoring rehabilitation.

When to use

Use these guidelines to help you monitor a client's rehabilitation progress after you have agreed on an individual rehabilitation plan (IRP) and created an action plan, which is the tool used to manage your client's claim.

Key principles

The key principles of managing and monitoring a claim include:

- managing the claim according to the level of claim complexity, ie a low complexity claim requires less intensive management
- proactively maintaining contact with the client, their employer and the treatment and rehabilitation providers
- proactively evaluating provider, treatment and medical reports
- tracking a client's progress against their rehabilitation goals as agreed with the client (in the action plan and in an IRP for claims in branches)
- reassessing the client's needs if flags or barriers arise
  - for STCC, also reassessing claim complexity and if the claim should be escalated to a branch
- checking the ongoing link between continuing incapacity (for work or independence at home) and the original covered injury and any entitlements
- closing the claim appropriately, see 'Move claim to Actioned Cases' when rehabilitation is completed. See also Situations for closing a claim.

Proactive claim monitoring

Why is proactive claim monitoring important?

Keeping in regular contact with the key stakeholders who influence the outcome of a client's rehabilitation journey is crucial to ensuring the rehabilitation stays on track. Regular communication ensures:

- you are providing clear information and setting expectations with each stakeholder so the client can achieve the best possible rehabilitation outcome
- the stakeholders are liaising and rehabilitation is occurring concurrently
- high quality rehabilitation is being provided according to a plan
- the rehabilitation is appropriate for the client's assessed needs
- any new flags or barriers are addressed as soon as possible to prevent small issues developing
- you take action if there is evidence that cover or ongoing entitlements need reviewing, eg if an underlying medical condition is impacting on a client's progress
- the rehabilitation goals and outcome date are still relevant
- you update the action plan and/or IRP when required.

How often should I be making contact?

The frequency and method of contact with the client and other stakeholders depends on the individual circumstances and the complexity of the claim. It can also change during the life of the claim, eg initially more frequently, and face to face contact, then less frequently.

If there are any flags or barriers evident, more frequent contact with the client, the employer and the provider is important.
The following table provides some recommendations for frequency of client contact in certain scenarios.

Scenario	Recommended frequency and mode of contact
A client on a graduated RTW programme under a SAW service is making excellent progress with functional recovery, and is well supported by their employer (STCC)	• Contact is in line with specialist appointments • The client is not showing any barriers to recovery so more frequent contact may not be needed • A face to face appointment is not required if the claim is low complexity and managed in the STCC **Note**: It is important to stay in regular contact with the SAW provider even if recovery is progressing well
A client is participating in a SAW programme and is struggling to make their physiotherapy appointments, is difficult to get hold of, has a terminally ill mother and is low in mood (Branch)	• Weekly contact with the client to ensure all barriers are identified and they are fully supported • Fortnightly contact with the employer and provider (more often as required) • Face to face contact is likely to be beneficial as the claim has more flags and barriers. An initial face to face meeting might be followed up by a case conference at work to ensure all parties are in agreement with the rehabilitation approach
A client is participating in a Back to Work programme and the provider is coordinating the client's rehabilitation which includes services, training for independence for a traumatic brain injury, physiotherapy and a work trial (Branch)	• At the beginning of the claim contact with the client is weekly due to the many things going on • When the rehabilitation has some direction after an IOA and IMA, and a Back to Work has been set up, frequency is less often as the provider takes a lead in coordinating services • Contact with the client and other parties will still be important and may coincide with key milestones or pre-agreed dates
A client has a permanent injury, is receiving two hours of home help per week and their needs have not changed in the last 12 months (Branch)	• Contact should be negotiated with the client. • As there are no active rehabilitation programmes in place, contact may be minimal but at least annually

Methods for proactive claim monitoring

Method	Description
Keep action plans up to date	Keeping an action plan up to date is important as it is a tool to help you manage your claim and ensure the client is making progress towards their goals
Review progress reports	Use tasks to remind yourself when progress reports are due and take note of any issues arising that you can have an impact on
Request treatment or medical reports	While you may receive copies of medical reports throughout the life of the claim, there are times you will need to proactively request them. This is particularly important when you are receiving conflicting information, or need to clarify what a client has told you about their treatment
Run programmes at the same time	When developing a client's rehabilitation plan, consider how services can run concurrently rather than one after the other as this can minimise time off work and speed up a client's return to independence
Take advantage of the service coordinator role	For SAW4 or Back to Work Programme claims managed in branch, consider asking the SAW or Back to Work Programme provider to act as the Service Coordinator who coordinates all the other providers involved

Method	Description
Have face to face meetings with the client (Branch)	Face to face meetings at key milestones help develop a good relationship with the client, better understand their individual circumstances, and assist in agreement on their rehabilitation.
Have case conferences	Consider using a case conference or regular case conferences to 'get all parties on side'. This is particularly helpful for complex cases or where one or more parties don't agree with the plan
Keep the IRP up to date (Branch)	As the client completes each component of their rehabilitation, add a completion date and ask the client to co-sign that that part of the rehabilitation is complete

Evaluating progress reports and new information

Evaluating progress reports allows you to identify any new information and ensure the client is progressing as expected. The important things to check for are outlined below.

Check on progress

Check whether:

- injury recovery is consistent with the treatment provider assessment
- reports are consistent with how the client is describing the treatment provider interaction
- the treatment provider is aware of any other rehabilitation the client is participating in, eg SAW
- treatment reports are consistent with the RTW plan, if relevant
- reports indicate progress as expected or if issues have been raised that need resolution. If there are issues, investigate:
  - quality of service provision
  - service delivery
  - reporting timeframes
  - medical issues
  - whether the goals are still suitable
  - whether the client understands how an intervention can help them achieve their goals
- any new recommendations are being made that may affect the overall outcome or RTW/RTI date, eg surgery is being planned that will extend the need for RTW support or home help.

Check for complications or changes

Check whether:

- the service provider has requested a service level change or funding for services not previously outlined in the plan
- any new barriers to recovery have been identified, either temporary or of a more long term or complex nature, eg a client has been diagnosed with cancer
- your client is reporting increased or disruptive levels of pain, eg pain that stops them from performing activities. If so, see:
  - Referring a client for pain management services
  - Vocational Medical Services (VMS).

Check ongoing entitlement and cover

Check whether:

- new information suggests there may be other factors impacting on the client's incapacity, eg the client may have an underlying medical condition contributing to their inability to carry out their usual home or work tasks
- there are questions over ongoing entitlement or cover. If so, consider:
- a discussion with the certifying practitioner
- the appropriateness of a Vocational Rehabilitation Review (VRR) or medical case review (MCR).

Check for non-compliance

Check whether the client:

has attended their appointments and if not, check the reason(s) for this. Discuss with the client and find out if additional support is needed to help them attend, eg do they need help with transport?

is aware of their obligations while receiving ACC entitlements and that they are complying with all their rehabilitation goals.

See also Managing non-compliance.

What to do if you're unsure

If you're unsure what impact any new information is having on a client's rehabilitation progress, then discuss the claim with one of your advisors, eg Triage Manager (TM), Medical Advisor (MA), Psychology Advisor (PA), or take the claim to a panel. For example, receiving an unclear medical certificate or an x-ray report showing mal-union of a fracture are both situations where you should consult your advisors.

If your initial monitoring of a claim raises concerns about rehabilitation progress, then face to face meetings and case conferences can provide good insight into the reasons behind any delays or problems. Consider VRR referral.

Assessing rehabilitation outcomes

Assessing how a client has progressed with any of their rehabilitation interventions is important to ensure they have either achieved their goals or require more support from ACC.

If the client has successfully and sustainably returned to work or independence, you can decide whether it is the right time to close a claim from active management.